(1) Is unemployed, is employed in a sheltered setting, or has markedly limited job skills and a poor work history.

(2) Exhibits inappropriate social behavior.

(3) Is unable, due to cognitive disorganization, to procure the financial assistance necessary to remain in the community.

(4) Is unable to establish or maintain a personal social support system.

(5) Requires that another individual assist with daily living skills, or

(6) Would have met the impaired role functioning criteria during the period under consideration if not for the treatment or other support services received.

5. Meet, at the time of the initial eligibility determination, at least:

(a) One of the following criteria:

(1) Is leaving supervised housing,

(2) Has had at least 10 State or private psychiatric hospitalizations within the past 2 years,

(3) Is 18 to 21 years old and leaving a residential treatment center, including a State hospital or an out-of-state placement, and needs assistance with transition to the adult mental health service sector,

(4) Has been hospitalized for at least 365 days in the past 2 years, or

(5) Is a homeless person or a person whose basic human needs are not being met or are being met inappropriately; or

(b) Two of the following criteria:

(1) Has had at least 2 incarcerations for misdemeanors at a local jail within the past 2 years,

(2) Has had 6 to 9 State or private psychiatric hospitalizations within the past 2 years,

(3) Has had at least 3 emergency room visits within the past 6 months, as the primary site for psychiatric interventions,

(4) Has been hospitalized for the treatment of mental illness for at least 180 days within the past 2 years,

(5) Is determined by the provider or the Administration to be vulnerable and at risk of harm to self or from others,

(6) Has multiple physical or mental disabilities, as well as needs not being met by a coordinated system of care, or

(7) Is in danger of losing the current place of residence.

D. Definition of Services:

1. "Case Management" means services which assist participants in gaining access to the full range of Medical Assistance services as well as to any additional needed mental health, medical, social, financial assistance, counseling, educational, housing, and other support services.

2. Maryland Medical Assistance shall reimburse for the following services under Mental Health Case Management when they have been documented as necessary and appropriate.

3. Assessment and reassessment.

(a) The assessment or reassessment involves the collection and integration of information concerning a participant's social, familial, cultural, medical, developmental, legal, vocational, psychiatric, and economic status to assist in the formulation of a service plan.

(b) The assessment or reassessment of the participant's status and service needs is conducted by the community support specialist and incorporates input from the participant, family members and friends of the participant, as appropriate, and community service providers.

(c) A home visit by the community support specialist or community support specialist associate is required.

(d) After an initial assessment, each participant shall be reassessed annually.

(e) A unit of service is defined as a completed assessment or reassessment.

4. Ongoing case management.

(a) Ongoing case management is the monthly provision of services. It may occur in conjunction with the assessment or reassessment.

(b) A unit of service is defined as at least two face-to-face contacts per month by the community support specialist or the community support specialist associate with the participant, including at least one visit to the participant's home or another suitable site for a homeless participant every 90 days, as well as the provision of all other necessary covered services.

(c) Services shall include:

(1) Planning. After the initial assessment is completed, a service plan shall be developed. Every 180 days thereafter, the service plan shall be updated, in conjunction with the participant's schedule for reassessments, to ensure that all services being provided remain appropriate and sufficient. The participant, any legal guardian, the participant's family, and any significant others, with the participant's consent, shall participate with the community support specialist, to the extent practicable, in the development and regular updating of the participant's service plan. The planning process is intended to promote consistent, coordinated, and timely service provision. Planning may include, as necessary and appropriate:

(aa) The case conference, which brings together service providers, other interested persons, and the participant as indicated, for the purpose of establishing, coordinating, revising, and reviewing service delivery;

(bb) Service planning for the development and periodic updating of the written, individualized service plan based on the participant's needs and stated goals;

(cc) Transitional care planning that involves contact with the participant or the staff of a referring or an accepting service provider, to plan for continuity of care as the services delivered change; and

(dd) Termination planning that prepares a participant for discharge from Mental Health Case Management services when appropriate.

(2) Linkage of the participant with services. The community support specialist shall assure that the participant has applied for, has access to, and is receiving the most appropriate services available to meet the participant's needs, such as mental health services, resource procurement, transportation, or crisis intervention. The community support specialist shall take the necessary action when this has not occurred. Included in this linkage process are:

(aa) Community supports development by contacting members of the participant's support network (e.g. family, friends, and neighbors) to mobilize assistance for the participant;

(bb) Crisis intervention by linkage of the participant with services on an emergency basis when immediate intervention is necessary;

(cc) Arranging for the participant's transportation to and from services;

(dd) Outreach in an attempt to locate service providers which can meet the participant's needs; and

(ee) Explaining the service plan to the participant and to the participant's family and friends, so as to enable and facilitate their participation in the plan's implementation.

(3) Monitoring of service provision. The community support specialist shall engage in ongoing interaction with the participant, the participant's family and friends as appropriate, and service providers. The community support specialist shall follow up after service linkage and then monitor service provision on an ongoing basis, to ensure that the agreed-upon services are provided, are adequate in quantity and quality, and meet the participant's needs and stated goals. The service plan may be revised to reflect changing needs identified from the service monitoring.

(4) Advocacy. The community support specialist shall attempt to empower the participant to secure needed services, and shall take any necessary actions to secure services in the participant's behalf. The community support specialist shall encourage and facilitate the participant's decision making and follow through on choices leading to accomplishment of the participant's goals.

E. Qualification of Providers:

1. Mental Health Case Management providers offer covered case management services to participants through a provider agreement signed with the Department of Health and Mental Hygiene. They are identified as Program providers by issuance of an individual account number.

2. General requirements for participation in the Program are that a provider shall meet all the conditions for participation as set forth in COMAR 10.09.36 General Medical Assistance Program Participation Criteria.

3. Specific requirements for participation in the Program as a Mental Health Case Management services provider include all of the following:

(a) Place no restrictions on the qualified recipient's right to elect to receive Mental Health Case Management and to choose a mental health case management services provider and other service providers;

(b) Employ appropriately qualified individuals as community support specialists, community support specialist associates, and community support specialist directors;

(c) Require that each community support specialist, community support specialist associate, and community support specialist director, within the employee's first year of employment, satisfactorily complete a State-approved training program for community support specialists, or its equivalent as approved by the Mental Hygiene Administration (MHA);

(d) Assure that:

(1) A participant's initial assessment is completed within 45 days after the recipient has been determined eligible for, and has elected to receive, Mental Health Case Management services, with extensions given as necessary for documented, client-related extenuating circumstances, and

(2) An initial service plan is completed within 10 days after completion of the initial assessment;

(e) Maintain a file for each participant which includes all of the following:

(1) An initial referral and intake form with identifying information,

(2) A written agreement for services signed by the participant or the participant's legally authorized representative and by the participant's community support specialist,

(3) An assessment, documented according to MHA's requirements,

(4) A service plan, updated at a minimum of every 180 days, which contains at a minimum:

(aa) A description of the participant's strengths and needs,
(bb) The diagnosis established as evidence of the participant's eligibility for Mental Health Case Management,
(cc) The goals of community support services, with expected target dates,
(dd) The proposed intervention,
(ee) Designation of the community support specialist with primary responsibility for implementation of the service plan, and
(ff) Signatures of the community support specialist, participant or the participant's legally authorized representative, and significant others if appropriate,

(5) An ongoing record of contacts made in the participant's behalf, which includes all of the following:

(aa) Date and subject of contact,
(bb) Person contacted,
(cc) Person making the contact,
(dd) Nature, content, and unit or units of service provided,
(ee) Place of service,

(6) Monthly summary notes, which reflect progress made towards the participant's stated goals;

(f) Require that another community support specialist or supervisor of the participant's community support specialist review the participant's service plan and the participant's progress, when the service plan is initially developed and when it is updated;

(g) Have formal written policies and procedures, approved by the Department, which specifically address the provision of Mental Health Case Management services to participants;

(h) Be available to participants and their families for 24 hours a day, 7 days a week;

(i) Designate specific qualified staff to provide Mental Health Case Management services, that must include at least one community support specialist and also may include community support specialist directors and community support specialist associates;

(j) Refrain from providing any other services to participants which would be viewed by the Department as a conflict of interest;

(k) Be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs which are applicable to participant;

(l) Maintain a current listing of mental health, medical, social, financial assistance, vocational, educational, housing, and other support services available to the seriously mentally ill;

(m) Safeguard the confidentiality of the participant's records in accordance with State and federal laws and regulations governing confidentiality; and

(n) Comply with the Department's fiscal reporting requirements and submit reports in the manner specified by the Department.

4. "Mental health case management services provider" means a lead agency of the Baltimore Mental Health Systems; Montgomery County, or a lead agency of Montgomery County Government; the Calvert County Health Department; St. Mary's County or the Washington County Mental Health Authority, which has been approved by the Medical Assistance Program to provide Mental Health Case Management.

5. "Baltimore Mental Health Systems (BMHS)" means the central authority designated for Baltimore City by the Department's Mental Hygiene Administration. BMHS is responsible for planning, managing and monitoring publicly funded mental health services for qualified adults.

6. "Calvert County Health Department" means the program designated by the Administration for Calvert County which is responsible for planning, managing, and monitoring publicly funded mental health services for qualified adults.

7. "St. Mary's Mental Health Authority" means the program designated by the Administration for St. Mary's County which is responsible for planning, managing, and monitoring publicly funded mental health services for qualified adults.

8. "Washington County Mental Health Authority" means the central authority designated by the Administration for Washington County and is responsible for planning, managing, and monitoring publicly funded mental health services for qualified adults.

9. "Lead agency" means an agency which has a written agreement with the BMHS, the Montgomery County Division of Crisis Stabilization and Adult Mental Health Services, the Calvert County Health Department, the St. Mary's Mental Health Authority, or the Washington County Mental Health Authority to provide mental health case management services for a defined service area.

10. "Case manager" means a community support specialist. The case manager may not be the participant's family member or a direct service provider for the participant.

11. "Community support specialist" means an individual who:

(a) Is employed by a lead agency to provide case management services to participants;

(b) Is chosen as the case manager by the participant or the participant's legally authorized representative; and

(c) Has at least a:

(1) Master's degree in a mental health field.
(2) Bachelor's degree in a mental health field and one year of mental health experience.
(3) Master's degree in a field other than mental health and one year of mental health experience, or
(4) Bachelor's degree in a field other than mental health and two years of mental health experience.

12. "Community support specialist associate" means an individual who:

(a) Is employed by a lead agency to assist community support specialists in the provision of Mental Health Case Management services to participants;

(b) Works under the supervision of a community support specialist, who delegates specific tasks to the associate; and

(c) Has at least:

(1) An associate of arts degree in a mental health field,

(2) A high school degree or the equivalent, and two years of experience dealing with individuals with mental illness.

13. "Community support specialist director" means an individual who:

(a) Directs and supervises a case management unit of a lead agency;

(b) Is a mental health professional with at least a Master's degree, as defined in COMAR 10.21.05; and

(c) Demonstrates a knowledge of the nature of serious mental illness and the system of mental health services available.